

Physician Assisted Suicide: Right to Life or Right to Death?

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Introduction

In 1997 the Death with Dignity Act was implemented in the state of Oregon. This piece of legislation enables a competent adult who desires to end their life access to a lethal dose of medication. In order for a person to qualify for assisted suicide under this act, they must be 18 years or older, a resident of Oregon, able to verbalize and understand the consequences of their decision, have a prognosis of six months or less to live due to a terminal illness, and convince a physician of their desire to end their life (Volker, 2007).

Although the Death with Dignity Act empowers individuals to control the timing of their death, physician assisted suicide still remains a controversial topic in today's society that raises many ethical questions. These questions include: Who is the true owner of our lives? Should relieving suffering always be the highest priority or does suffering occur for a reason? Is suicide a purely individual choice (Mathes, 2004)?

The answers to the above questions are subjective, yet healthcare workers deal with the difficult issues associated with end-of-life care on a daily basis. Since patients and families frequently ask nurses to provide information about support in dying, it is important for nurses to thoroughly understand the topic of physician assisted suicide regardless of whether it is legally permitted within the State where they are working (Ersek, 2004). The purpose of this paper is to describe benefits and disadvantages of assisted suicide and to discuss the ethical reasoning behind both of these opposing viewpoints.

Review of Literature

Throughout the literature, there are many arguments that support the prohibition of physician assisted suicide. One of the most obvious arguments is that health care providers are

supposed to save lives—not take them. (de Vocht & Nyatanga, 2007). This principle of nonmaleficence can be traced back in time to Hippocrates, a Greek physician, who states this duty as “I (healthcare provider) will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them” (Beauchamp & Childress, 2009, p. 149). In other words, this statement can be interpreted as “do no harm”. The American Nurses’ Association supports the notion that active participation in assisted suicide goes against the ANA Code of Ethics for Nurses (2001). Helping a client take their own life is not only in contrast with ethical traditions of nursing but it could also discourage clients from seeking out medical care due to fear (Ersek, 2004).

In response, proponents for assisted suicide argue that it is well within the patient’s right to decide whether he or she lives or dies. Emphasizing the importance of the principle of autonomy, they feel that quality of life is a very personal opinion. By preventing clients from taking their life, they feel healthcare providers are being paternalistic and imposing their views onto their patients. Some also feel that it is pride, not altruism, which inhibits healthcare workers from supporting assisted suicide. They argue medical professionals do not like to admit that they cannot fix a situation, because it causes them to acknowledge their own limitations and evokes a feeling of failure. (de Vocht et al, 2007).

Another reason many dislike physician assisted suicide is their belief that it might eventually lead to involuntary euthanasia. This slippery slope conjecture is based on the idea that small steps will eventually lead to an inevitable chain of events that cannot be stopped once started. This notion is supported by statistics gathered from the Netherlands that state “roughly 1,000 patients die due to the result of an end-of-life decision made without their explicit consent”

(Dieterle, 2007, p. 129). Therefore advocates of this theory feel that the best way to prevent the establishment of involuntary euthanasia is by barring assisted suicide.

In contrast, supporters of physician assisted suicide feel that the slippery slope argument is an exaggeration. Since the passage of the Death with Dignity Act in Oregon, involuntary euthanasia is far from being a reality of the status quo in the United States. This is a living example that demonstrates assisted suicide can be passed without spiraling out of control. Therefore support of the slippery slope argument is closed minded and shows little faith in human nature (Dieterle, 2007).

However, the possibility that patients might be coerced into participating in assisted suicide against their will is very concerning to many people. Opponents to legalizing assisted suicide fear that patients could be persuaded by their family or insurance companies into requesting support in dying. A specific concern exists for vulnerable populations which include the elderly, poor, and minorities. These groups of people may be easily manipulated and lack the means to defend themselves. In summation, it is very possible that abuses of law could occur (Dieterle, 2007).

The argument also exists that legalizing assisted suicide would make it easier to regulate these practices. One result of not legalizing assisted suicide could be that people might utilize the “euthanasia underground” as a source of relief. These people are very determined to die and may go to other countries or fall back on illegal methods to reach their goal. This not only makes it hard to control what is happening, but some people are also dying in ways that they do not prefer (de Vocht et al, 2007).

Since assisted suicide is a complex issue, many feel that forming comprehensive legislation that is safe is an impossible task. The current Death with Dignity Act uses many terms

which are subjective. For example, there is no definite way to determine the exact time and date when a person will die. Therefore the 6-month prognosis is not reliable even if it is agreed upon by two different physicians. In addition, mistakes in assisted suicide are permanent and cannot be corrected (Gannon & Garland, 2008).

Conversely, assisted suicide supporters argue physicians are already familiar with facilitating the death of their patients. Currently, “In all 50 states in the US, patients have the right to refuse treatment and be allowed to die. Furthermore, all 50 states have procedures in place for allowing substituted judgments for the refusal of treatment” (Dieterle, 2007, p. 132). Although end-of-life issues are complex, legal support for physicians comfortable with this process should continue.

Another argument against assisted suicide is that it could encourage people to give up and take the easy way out. By allowing a person to take their life when they feel hopeless, it might give off the wrong impression to the public that when life becomes hard it is acceptable to quit. (Dieterle, 2007). Instead of focusing on ending life, emphasis should be put on how to enhance palliative care.

On the contrary, proponents for assisted suicide argue that the people who are requesting it are not hopeless and depressed. The clients who utilize the Death with Dignity Act in Oregon, Linda Ganzini states, “are not so much depressed as determined” (Schwartz & Estrin, as cited in Dieterle, 2007, p. 134). Ironically, these people say that assisted suicide actually instills hope in people because they feel they have a way of controlling their life if it becomes too unbearable.

Conclusion

While there many arguments for and against assisted suicide, the answer to the question of whether it is right or wrong remains ambiguous. One reason for the lack of clear cut answers

is that assisted suicide is an ethical issue which is dependent on a person's values, morals, religion, and experiences. In general, the topic of end-of-life decision making is very sensitive and evokes strong emotions and opinions. Instead of debating the issues involved with assisted suicide, this paper merely describes pertinent arguments that have been presented by both sides.

There are many nursing implications that are associated with assisted suicide. Among these is the importance for nurses to be aware of their own beliefs about end-of-life care. Self-awareness will prepare nurses for obstacles they will face when dealing with death. Another implication is that nurses need to be cognizant of politics and legal authority. Becoming active in political processes, nurses can work to ensure that they will not be forced into doing procedures that come in direct conflict with their beliefs.

Writing this paper has taught me that autonomy is a very controversial issue in the health profession. I have also learned that there is a fine line between being a patient advocate and acting paternalistically. There is also a very fine line between providing a patient with information and influencing their decision making process. I plan to use this knowledge in my practice by being aware of my own biases and respecting the beliefs of my patients. I have come to the conclusion that facing ethical issues is inevitable part of a nurse's professional practice.

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